



A lifetime of partnership. A lifetime for growth.

Participant Profile Packet

Updated as of August 2017

Dear Parent/Guardian and Interested Participant,

Thank you for your interest in having your son/daughter becoming a participant at Connection of Friends.

Connection of Friends was created to provide structured programming for participants while encouraging socialization and growth. To ensure the safety and compatibility of our program with your son/daughter, we ask that all parents/guardians and participants complete the attached forms. For your convenience we have included two versions of the Participant Profile Form for your son/daughter depending on their literacy level on our website. Please have your son/daughter only fill out the version that best fits their level. Once your completed Participant Profile Packet is received, we will be contacting you for a meeting to outline the specifics of our programming as well as answer your questions.

The following forms to be filled out:

- Parent/Guardian Information Form
- Participant References Form
- Participant Profile Form: Readable Version OR
- Participant Profile Form: Visual Version

Please return all three completed forms to our mailing address:

Terry and Ginny Kline
1502 Coloma Place
Wheaton, IL 60189

Or email your completed forms to Sarah Donnelly, Executive Director at sdonnelly@connectionoffriends.org. If you have any questions, please call Connection of Friends at (630) 260-0922 and ask for our Program Director.

Sincerely,

Sarah Donnelly
Executive Director

CONNECTION OF FRIENDS
PARENT/GUARDIAN INFORMATION FORM

GENERAL INFORMATION

Today's Date:	
Participant's Name:	
Gender:	
Birth Date and Age:	
School or Employer:	
Primary Diagnosis:	
Secondary Diagnosis:	
Medical Diagnosis:	
Verbal or non-verbal communicator:	

SEIZURE INFORMATION

In case of a seizure, you will be notified. Please know that if there are any medical concerns,(including, but not limited to Grand Mal seizure), 911 will be called.

Does the participant have seizures?	
What type?	
How frequently do seizures occur?	
Are there side effects to medication? If so, please describe.	

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name:	
Street Address:	
City/Zip Code	
Home Phone:	
Cell Phone:	
Employer & Work Phone:	
E-Mail Address:	

PARENT/GUARDIAN INFORMATION	
Parent/Guardian Name:	
Street Address:	
City/Zip Code	
Home Phone:	
Cell Phone:	
Employer & Work Phone:	
E-Mail Address:	
EMERGENCY CONTACT	<i>Please give the name of a relative or friend who can respond for your son/daughter in case of an emergency when you cannot be reached.</i>
Name:	
Relationship:	
Home Phone:	
Cell Phone:	
Work Phone:	
PHYSICIAN & INSURANCE INFORMATION	<i>Please give the name of a doctor who may be called for your son/daughter should emergency care be necessary and you cannot be reached. <u>If we cannot reach the physician, 911 will be called.</u></i>
Doctor:	
Phone:	
Doctor Restrictions:	
Insurance Carrier:	
Policy #:	
Group #:	
Name of Insured:	
Medicaid #:	

ASSISTIVE NEEDS	
Mobility (check which one applies):	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker
	<input type="checkbox"/> Other (describe)
Wheelchair type:	<input type="checkbox"/> Electric <input type="checkbox"/> Manual
Transfer:	<input type="checkbox"/> Independently <input type="checkbox"/> Needs Assistance
Doctor approval for transfer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedic Equipment used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Special instructions:	
Hard of hearing/deaf	<input type="checkbox"/> Yes <input type="checkbox"/> No
Audio equipment used	<input type="checkbox"/> Yes <input type="checkbox"/> No
Special instructions:	
Augmentative and Alternative Communication (AAC)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Device used:	
Level of independence (fully, hand over hand):	
How is device utilized:	
DAILY LIVING SKILLS	
Feeding assistance required:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of feeding assistance	<input type="checkbox"/> Visual supports <input type="checkbox"/> Auditory reminders <input type="checkbox"/> Sequencing
	<input type="checkbox"/> Cutting food <input type="checkbox"/> Other (describe)
Special diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe diet:	
Can toilet independently	<input type="checkbox"/> Yes <input type="checkbox"/> No
Independence with sanitary skills during menstruation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of toileting supports needed:	<input type="checkbox"/> Visual supports <input type="checkbox"/> Auditory reminders <input type="checkbox"/> Sequencing

RECREATIONAL PROGRAMS	
Does participant attend recreational programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which ones?	
What support ratio does your participant have during programming?	
OTHER SOCIAL PROGRAMS	
Does participant attend other socially based programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which ones?	
What support ratio does your participant have during programming?	
SENSORY	
Does participant have sensory issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe:	
Does participant seek sensory input?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe:	
Does participant take breaks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe preferred breaks (movement, quiet room, puzzles, blocks, deep breathing etc.):	
SUPPORTS	
Does participant utilize supports?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are supports visual or written?	<input type="checkbox"/> Visual <input type="checkbox"/> Written
Schedules?	<input type="checkbox"/> Yes <input type="checkbox"/> No
First This Than That?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Stories?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	

BEHAVIORS AND STRATEGIES	
Stemming	[] Yes [] No
Aggression (biting, hitting, pulling hair, etc.)	[] Yes [] No
Echolalia	[] Yes [] No
Rigidity	[] Yes [] No
Anxiety	[] Yes [] No
Self-injury	[] Yes [] No
Other:	

BEHAVIOR STRATEGIES

If any behaviors listed were answered with “yes”, please outline helpful techniques that work best including breaks, supports and positive reinforcement in the form of token systems, etc. utilized at home/school/work environment. The more information given the better COF can create a safe and structured environment for your participant.

MEDICAL INFORMATION	
Does participant have allergies?	[] Yes [] No
Describe in detail:	

MEDICATION

Please provide us with a list of the current medication being taken. This information is used in emergency situations. Each form of medication must be in the original container from the pharmacy. Container label must include doctor’s name, patient’s name, medication strength, dosage and date. **IF TAKING MORE THAN THREE MEDICATIONS, PLEASE ATTACH A SEPARATE SHEET WITH THE INFORMATION.**

Can the participant self-administer their medication? Yes No

Permission for COF staff to administer medication during community outings? Yes No

Medication Name	Use	Dosage	Directions	Time
<i>ex: Clonazepam</i>	<i>Seizures</i>	<i>1.0 mg</i>	<i>Crushed in juice</i>	<i>every 8am/6pm</i>

Please list any medication side effects: _____

PROGRAMMING

What programming day(s) are you interested in? (Check what applies).

Programming Day	Programming Time	Interested
Monday	Noon-3:00 pm	
Monday (Dinner & Dancing)	3:00-6:00 pm	
Tuesday	9:00 am-3:00 pm	
Tuesday	Noon-3:00 pm	
Wednesday	Noon-3:00 pm	
Wednesday	3:00-6:00 pm	
Wednesday	Noon-6:00 pm	
Thursday	Noon-3:00 pm	
Thursday	3:00-6:00 pm	
Thursday	Noon-6:00 pm	
Friday	9:00 am-3:00 pm	
Saturday Night Socials	6:00-9:00 pm	

What are you and your son/daughter most looking to gain from this program?

What are his/her strengths?

What are his/her favorite activities?

What are his/her improvement goals?

Please provide any additional information regarding your son/daughter that you feel is important and has not been covered in this parent/guardian information form:

Agreement and Signature

By submitting this form along with the Participant References Form and signing below, I attest to the truthfulness of all information provided. I understand that if my son/daughter is accepted as a participant, any false statements, omissions, or other misrepresentations made by me on any of the forms may result in termination of services. I understand that Connection of Friends may conduct participant references prior to the admittance into our program.

Parent/Guardian NAME (PRINT)

Parent/Guardian SIGNATURE

DATE